PLEASE PRINT
Attach additional pages if more space is needed

_____**Notification**
_____**Treatment Plan**

HealthChoice/DHMH

Please Circle One

Initial Treatment Plan for:

- **Ambulatory Detox**
- **Intensive Outpatient Treatment**
- **Methadone Maintenance**
- **Traditional Outpatient Treatment**

Date contact made to MCO:_____ Time:_____am / pm	MCO Name _____ Contact Name_____	Date confirmation received from MCO:_____ Time:_____ am / pm

Please complete all sections. For confidentiality purposes, please do not write the client's name in the body of the treatment plan. This information has been disclosed to you from records protected by Federal confidentiality rules (CFR 42 – part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR 42-Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate any alcohol or drug abuse patient.

1.Client's First Name Only	2. Client's Date of Birth _____/_____/_____ Mo Day Yr	3. Client's Sex M___ F___	4a. Client's MCO Number 4b.Client's MA Number
5. Group Number*	6. Client's Address & Phone Number		

7. Clinician's Name (Printed) _____ _____ Clinician's Signature Date	8. Clinic/Program Name, Address & Phone number

9. MA Provider Number	10. Referral Source	11. Primary Care Physician	12. Date of Last Exam

13a. Client Pregnant? Yes____ No____ 13b. If Yes, Due Date _____	14. OB/GYN:_____ a. Pre Natal Appt Scheduled:_____ b. Pre Natal Appt Completed:_____ c. OB/GYN Knows of Pregnancy? Yes____ No____

15. Date Present Treatment Began (mo, day, yr)

16. Diagnosis (Please complete all axes.) Use DSMIV Codes

AXIS I

AXIS II

AXIS III

AXIS IV

AXIS V (GAF)

17. Reason for Seeking Treatment/Motivation for Treatment

18. Substance Abuse History

Drugs of Choice	Last Use I Route	Date Use Began I Frequency	Toxicology Screen Date I Results
Alcohol			
Barbiturates			
Cocaine			
Opioids			
Other			

19a. History of Delirium Tremens	19b. History of Blackouts	19c. Alcohol Related Seizures
Yes_____ Last date_____ No_____	Yes_____ Last Date_____ No_____	Yes_____ Last Date_____ No_____

*

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20. Substance Abuse Treatment History (Last 3 Years)

21. Medical Complications

Allergies_____ Heart_____
Amputee_____ Hepatitis_____
Cirrhosis_____ HIV_____
Diabetes_____ Hypertension_____
Enlarged Liver_____ Jaundice_____
Gunshot_____ Seizures_____
Head Injury_____ STDs_____
Hearing Impaired____ Other_____

22. List All Medications (including Methadone/LAAM)

Type	Dosage	Start Date	Response

23. If medications are being administered by someone other than yourself, please identify.

24. Suicidal/Homicidal Behaviors? No____ Yes____ Clarify_____
If yes, is client able to contract for safety?_____
List recent hospitalization or attempts_____

25. If client has a co-occurring psychiatric diagnosis, is client in treatment? Yes____ No_____

26. Client's Mental Health Professional_____ Phone Number_____
Release of Information Signed? Yes_____ No_____

27. Psychosocial Functioning:

Domestic Violence_____
Drugs in the Home_____
Education_____
Legal Problems_____
Primary Support System_____
Recovery Environment_____
Working_____
Other_____

28. Brief Mental Status

29. Assessment Tools

MAST Score_____
POSIT Score_____
ASAM Criteria_____
Dimensions: I_____ II_____ III_____ IV_____ V_____ VI_____
Level of Placement Assigned_____

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30. Statement of Problem/s

Goals related to Presenting Problems (use finite / measurable / observable terms)**
**12 STEP/Community Support/Spirituality

Short term:
1)

2)

3)

Long term:
1)

2)

3)

_____ _____
Client's Signature Date

31. Type of Treatment Requested

	Frequency/Week	Duration of **EACH** Session
IOP_____	_____	_____
Methadone Maintenance/LAAM_____	_____	_____
Individual	_____	_____
Group____	_____	_____
Other ____	_____	_____

32. Anticipated Discharge Date:_____
After Care Plan:

33. Comments (e.g. employment, family, housing, health status, socialization, support system)

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For Ambulatory Detox Only

1. Vital Signs

BP_____ Pulse_____ Temperature_____ Respiration_____ Date taken_____
Time taken_____am/pm

2. Withdrawal Symptoms

Agitation_____
Chills_____ Piloerection (goosebumps)_____
Cramping_____ Rhinorhea (runny nose)_____
Cravings_____ Shakes_____
Diarrhea_____ Sweating_____
Dilated pupils_____ Tremors; Fine _____ Gross_____
Lacrimation (runny eyes)_____ Vomiting_____
Muscle aches_____ Other_____
Nausea_____

3. Medical Detox Protocol
(Explain below or attach as a separate sheet)